Health, Allergy & Medication Questionnaire (HMQ)

medco

Your answers to the following questions will help us provide your prescription drug benefit services including, for example, filling prescriptions and alerting your doctor about possible medication problems. To best serve you, we need to know if you or any eligible person in the household has any known allergies, conditions or diseases.

- Please complete the questionnaire for each person in the household eligible for prescription drug benefits with **Medco By Mail** mail-order pharmacy.
- If you need additional forms you may call your toll-free Member Service Number or you may print a form on-line at www.medco.com.
- **Return this questionnaire with your prescription or refill order form in the envelope marked MEDCO BY MAIL Order Center.**

Section 1: Member Identification and Contact

Group Number

Member Number
(Located on your pharmacy benefit card and/or in your benefits information)

Daytime telephone Number

Member/Subscriber First Name   M.I.   Last Name

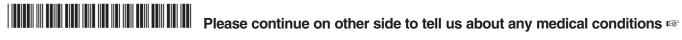Street Address/Apt. No.   City   State   Zip

Section 2: Drug Allergy Conditions

For each covered family member, include their name, date of birth and gender.
For each family member fill in the circle **ONLY** if an allergy or bad reaction happened anytime in the past. If your medication is not listed, please print the name of the medication allergy in the bottom section of this chart.
Correct way to mark circles: ⬤   Please use blue or black ink.

	Member	Spouse	Dependent	Dependent	Dependent
First Name:					
Add last name if different than member					
Date of Birth:	MM/DD/YYYY	MM/DD/YYYY	MM/DD/YYYY	MM/DD/YYYY	MM/DD/YYYY
Gender:	○ M ○ F	○ M ○ F	○ M ○ F	○ M ○ F	○ M ○ F
Penicillin/cephalosporin Antibiotics (e.g. ampicillin, Keflex®)	○	○	○	○	○
Tetracycline antibiotics	○	○	○	○	○
Erythromycin, Biaxin®, Zithromax®	○	○	○	○	○
Codeine (e.g. Tylenol #3®)	○	○	○	○	○
Non-steroidal anti-inflammatory drugs (NSAIDs) (e.g. ibuprofen)	○	○	○	○	○
Aspirin (salicylates)	○	○	○	○	○
Sulfa drugs	○	○	○	○	○
Iodine	○	○	○	○	○
Print other drug allergies not listed above in the space provided. Example: *morphine.*					

Please continue on other side to tell us about any medical conditions ☞ 10/04
MGNPRF

Section 3: Medical Conditions

Please list in the appropriate column the names of each family member enrolled. Then, for each family member, fill in the circle next to each condition if a doctor ever said *that particular family member* has the condition.

First Name:	Member	Spouse	Dependent	Dependent	Dependent
Heart failure (weak heart)	○	○	○	○	○
High blood pressure (hypertension)	○	○	○	○	○
Heart attack or angina	○	○	○	○	○
High cholesterol (hypercholesterolemia)	○	○	○	○	○
Stroke	○	○	○	○	○
Chronic bronchitis or emphysema (COPD)	○	○	○	○	○
Asthma	○	○	○	○	○
Allergies, runny nose, hay fever (allergic rhinitis)	○	○	○	○	○
High blood sugar (diabetes)	○	○	○	○	○
Thyroid disease	○	○	○	○	○
Peptic, stomach, or duodenal ulcer	○	○	○	○	○
Gastric reflux, heartburn, or esophagitis (GERD)	○	○	○	○	○
Inflammatory bowel disease (colitis, Crohn's disease)	○	○	○	○	○
High pressure in the eyes (glaucoma)	○	○	○	○	○
Seizures	○	○	○	○	○
Poor circulation in the legs (peripheral vascular disease)	○	○	○	○	○
Trouble with blood not clotting properly	○	○	○	○	○
Enlarged prostate (benign prostatic hyperplasia, BPH)	○	○	○	○	○
Arthritis	○	○	○	○	○
Osteoporosis	○	○	○	○	○
Depression	○	○	○	○	○
Migraine headaches	○	○	○	○	○
Print other medical conditions not listed above in the space provided. Example: - *glaucoma*					

USING MEDCO BY MAIL? It's available to you at **NO EXTRA CHARGE, NO SIGN-UP.** Experience the convenience and savings millions of people are enjoying. Learn more by visiting us a **www.medco.com**.

> **Please return the questionnaire with your prescription or refill order form in the envelope marked MEDCO BY MAIL Order Cener.**

Did you complete both sides?   **Thank you very much.**

MGNPRF